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1.0 Description of the Service

Obstetrics is a branch of medical science that deals with maternity care, including antepartum care, labor and delivery, and postpartum care. Standards of care are published by the American College of Obstetricians and Gynecologists (ACOG), Centers for Disease Control (CDC), and the American College of Nurse Midwifery (ACNM) for the perinatal care of the mother.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.1 Regular Medicaid

Female recipients in this eligibility category are eligible for antepartum, labor and delivery, and postpartum care.

Note: Please refer to Basic Medicaid Billing Guide

2.1.2 Medicaid for Pregnant Women

Female recipients of all ages with Medicaid for Pregnant Women (MPW) coverage are eligible for pregnancy-related antepartum, labor and delivery, and postpartum care as well as services for conditions that—in the judgment of their physician—may complicate pregnancy. The eligibility period ends on the last day of the month in which the 60th postpartum day occurs according to 42 CFR 447.53(b)(2).

Refer to **Section 5.1** for information on referring MPW recipients for non-obstetrical pregnancy-related treatment services.

2.1.3 Undocumented Aliens

In accordance with 42 CFR 440.255(c), undocumented aliens are eligible only for emergency medical services, which includes labor and vaginal or cesarean section (C-section) delivery as defined in 10A NCAC 21B.0302. Services are authorized only for actual dates that the emergency services were provided.

Note: The local department of social services in the county where the alien resides determines eligibility coverage dates when the emergency service is for labor and delivery (vaginal or C-section delivery). The Division of Medical Assistance (DMA) determines eligibility coverage for all other emergency services, including miscarriages and other pregnancy terminations.

2.1.4 Presumptive Eligibility

Section 1920(b) of the Social Security Act allows for a pregnant woman who is determined by a qualified provider to be presumptively eligible for Medicaid to receive ambulatory antepartum care, including pharmacy, laboratory, and diagnostic tests, while her eligibility status is being determined.

The pregnant woman must apply for Medicaid no later than the last day of the month following the month she is determined presumptively eligible. If the pregnant woman fails to apply for Medicaid within this time period, she is eligible only through the last calendar day of the month following the month she is determined presumptively eligible. If the pregnant woman applies for Medicaid within this time frame, she remains presumptively eligible for Medicaid until the local department of social services makes a determination on her application.

In the case of a woman who does not file an application by the last day of the month following the month during which the provider makes the determination, the presumptive eligibility period ends.

Note: Presumptive eligibility is limited to one presumptive eligibility period per pregnancy.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination****** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

a. that is unsafe, ineffective, or experimental/investigational.
b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does NOT eliminate the requirement for prior approval.

b. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

***Basic Medicaid Billing Guide*:** http://www.ncdhhs.gov/dma/medbillcaguide.htm

EPSDT provider page: http://www.ncdhhs.gov/dma/EPSDTprovider.htm

3.0 When the Service Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

3.1 General Criteria

Medicaid covers obstetrical services when they are medically necessary and

a. the procedure is individualized, specific, and consistent with symptoms or confirmed diagnosis of the pregnancy under treatment, and not in excess of the recipient's needs;

b. the level of service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and

c. the service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Antepartum Care

The initial and subsequent antepartum visits include the history physical examination; and recording of weight, blood pressure, fetal heart tones, and laboratory tests including urinalysis and urine hemoglobin analysis performed at the time of the visit.

3.2.1 Antepartum Visits

The frequency and number of antepartum visits are determined by the needs of the recipient. A recipient with an uncomplicated pregnancy is generally seen on the following schedule:

a. Every 4 weeks for the first 28 weeks of gestation

b. Every 2 to 3 weeks until the 36th week of gestation

c. Weekly from the 36th week of gestation until delivery

Note: the recipient may be seen more frequently if her condition warrants.

3.2.2 Individual Antepartum Services

Individual antepartum services are covered if

a. a pregnancy is high risk and requires more than the normal amount of services for a routine pregnancy or
b. antepartum care is initiated less than three months prior to delivery.

3.2.3 Counseling

Refer to Clinical Coverage Policy #1M-8, Maternity Care Coordination on DMA's Web site at http://www.ncdhhs.gov/dma/mp/mpindex.htm for information on counseling for smoking cessation, contraceptive management, and, if applicable, health and behavior intervention.

Refer to Clinical Coverage Policy #8C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers, on DMA's Web site at http://www.ncdhhs.gov/dma/mp/mpindex.htm for information on behavioral health treatment.

Refer to Clinical Coverage Policy #XXX, Dietary Evaluation and Counseling, on DMA's Web site at http://www.ncdhhs.gov/dma/mp/mpindex.htm for information on other dietary counseling services.

3.2.4 Fetal Surveillance Testing

Medicaid covers medically necessary fetal surveillance testing. Refer to Clinical Coverage Policy #1E-4, Fetal Surveillance, on DMA's Web site at http://www.ncdhhs.gov/dma/mp/mpindex.htm for additional information.

3.2.5 Case Management

Case management services for pregnant women are covered through the Baby Love Program or the Human Immunodeficiency Virus (HIV) Case Management policy. Refer to DMA's Web site at http://www.ncdhhs.gov/dma/mp/mpindex.htm for additional information on maternity care coordination services and HIV case management services.

3.3 Package Services

3.3.1 Antepartum Package Services

Antepartum package services are covered when the attending provider rendering the antepartum care does not perform the delivery. The attending provider or group provider must have seen the recipient for at least three consecutive months during her pregnancy **with the intention of performing the delivery**.

Note: Individual antepartum visits are not covered in conjunction with antepartum package services. Refer to **Attachment A** for billing instructions.

3.3.2 Global Obstetrics Services

Antepartum care, labor and delivery, and postpartum care are covered as an all-inclusive service when

a. antepartum care was initiated at least three months prior to the delivery and
b. the same provider who renders the antepartum care performs the delivery.

3.3.3 Postpartum Package Services

Postpartum package services are covered when the attending provider

a. has not provided any antepartum care, but performs the delivery and provides postpartum care; or

b. has not provided any antepartum care and did not perform the delivery, but performs all postpartum care.

3.4 Consultations

Inpatient and outpatient consultations are covered when medical records substantiate that the services are medically necessary.

Note: Prior approval is required for some services for MPW recipients. Refer to Section 5.1 for additional information.

3.5 Labor and Delivery

Vaginal delivery includes episiotomy, the delivery of the placenta, external cephalic version, and special services associated with delivery.

Note: When there are extenuating circumstances and a certified or licensed provider other than the attending provider or provider group performs the episiotomy, it may be covered as a separate procedure. When a provider other than the attending physician or physician group performs the delivery of the placenta, it may be covered as a separate procedure. Refer to **Section 5.0** for additional information.

3.5.1 Anesthesia

Anesthesia services are covered separately. Refer to Clinical Coverage Policy #XXXXX, Anesthesia, on DMA's Web site at http://www.ncdhhs.gov/dma/mp/mpindex.htm for information on anesthesia and obstetrics.

3.5.2 Complications Related to Delivery

Medicaid covers complications related to delivery when the diagnosis substantiates medical necessity.

3.5.3 Multiple Births

If the patient delivers multiple babies, vaginally or by C-section, the appropriate modifiers and diagnosis codes must be used for reimbursement. Refer to **Attachment A.**

3.5.4 Stand-by Services

Medicaid covers physician stand-by services for

a. Care provided to the mother during a **high-risk delivery**

b. Attendance at delivery and initial stabilization of the newborn during a high-risk delivery

c. Anesthesia stand-by is defined as the anesthesiologist's or certified registered nurse anesthetist's (CRNA's) standing by until it is determined whether services are required to administer and/or monitor anesthesia.

Note: Physician stand-by service is covered for anesthesia services. This service is available only for physician stand-by services at high-risk deliveries. Only

stand-by services related to the mother can be billed. The service must be requested by a physician and a diagnosis substantiating the high risk must be documented on the claim. Medical records documenting the high-risk delivery and the need for stand-by services are not required with the claim submission, but must be available for DMA or its agents upon request (refer to **Attachment A**).

3.6 Postpartum Care

Postpartum services encompass management of the mother after delivery and during the postnatal period. Components of this service may include postpartum examination and contraceptive counseling.

Postpartum care services are covered through the end of the month in which the 60th postpartum day occurs.

Note: For continued services after the 60th day, refer MPW recipients to the Department of Social Services for continuing eligibility determination.

3.6.1 Vaccinations

Medicaid covers vaccinations for measles, mumps, rubella (MMR)/rubella component for women who do not have evidence of immunity and other vaccinations as recommended by the Advisory Committee on Immunization Practices (ACIP) and the Center for Disease Control (CDC). The vaccine is provided upon completion or termination of pregnancy and before discharge from the health-care facility.

The ACIP recommendations for varicella vaccination indicate that women who do not have evidence of immunity should receive the first dose of varicella vaccine upon completion or termination of pregnancy, according to ACIP protocol, and before discharge from the health care facility. The second dose should be administered between 4 and 8 weeks after the first dose. Medicaid covers the varicella vaccine series when provided according to this schedule and if the recipient is eligible for Medicaid on the day the service is provided.

Refer to **Attachment A** for a list of covered procedures.

4.0 When the Service Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

4.1 General Criteria

Obstetrical services are not covered when

a. the recipient does not meet the eligibility requirements listed in **Section 2.0;**
b. the recipient does not meet the medical necessity criteria listed in **Section 3.0;**
c. the procedure unnecessarily duplicates another provider's procedure; or
d. the procedure is experimental, investigational, or part of a clinical trial.

4.2 Emergency Services for Undocumented Aliens

The following antepartum and postpartum services are not covered for undocumented aliens for emergency services.

a. ICD-9-CM Procedure Codes and Descriptions

66.21	Bilateral endoscopic destruction or occlusion of fallopian tubes; Bilateral endoscopic ligation and crushing of fallopian tubes
66.22	Bilateral endoscopic destruction or occlusion of fallopian tubes; Bilateral endoscopic ligation and division of fallopian tubes
66.29	Bilateral endoscopic destruction or occlusion of fallopian tubes; Other bilateral endoscopic destruction of occlusion of fallopian tubes
66.31	Other bilateral destruction or occlusion of fallopian tubes; Other bilateral ligation and crushing of fallopian tubes
66.32	Other bilateral destruction or occlusion of fallopian tubes; Other bilateral ligation and division of fallopian tubes
66.39	Other bilateral destruction or occlusion of fallopian tubes; Other bilateral destruction or occlusion of fallopian tubes

b. CPT Procedure Codes and Descriptions

58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
58605	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)
58611	Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure)(List separately in addition to code for primary procedure)
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)
58671	Laparoscopy, surgical; with occlusion of oviducts by device (e.g., band, clip, or Falope ring)
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
59425	Antepartum care only; 4–6 visits
59426	Antepartum care only; 7 or more visits
59430	Postpartum care only (separate procedure)

59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59515	Cesarean delivery only; including postpartum care

The following CPT procedure codes will be considered for coverage only in an emergency situation such as an ectopic pregnancy:

58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58700	Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)

Sterilization procedures are not included in the definition of emergency services and therefore are not covered for undocumented aliens. Refer to **Section 2.1.3.**

4.3 Stand-by Services

a. Medicaid does not cover stand-by services for pre-anesthesia evaluations.

b. Medicaid does not cover stand-by services for the mother and for the newborn when provided by the same provider.

5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

5.1 Prior Approval for MPW Recipients

Prior approval is required for MPW recipients when the physician determines that any of the services listed below are needed for the treatment of a medical illness, injury, or trauma that many complicate the pregnancy.

a. Podiatry

b. Chiropractic

c. Optometric and optical services

d. Home health

e. Personal care services

f. Hospice

g. Private duty nursing

h. Home infusion therapy

i. Durable medical equipment
j. Dental

Refer to the specific clinical coverage policies on DMA's Web site at http://www.ncdhhs.gov/dma/mp/mpindex.htm for specific requirements for prior approval for MPW recipients.

5.2 Limitations

The following limitations apply to obstetric care services.

a. Individual delivery procedures (vaginal delivery and delivery of placenta) are not covered more than once in a 225-day period.

   Note: When there is more than one pregnancy within 225 days and both pregnancies result in separate deliveries on different dates of service within 225 days, the service is covered.

b. Antepartum care package services are covered once during the recipient's pregnancy. In special circumstances (for example when the recipient moves), up to 3 different providers can bill for 59425 (Antepartum care; 4–6 visits). This does not apply to different providers in the same group.

c. Postpartum care services are covered through the end of the month in which the 60th postpartum day occurs. Refer to section 3.6.

d. Stand-by services related to the mother for a high-risk delivery are limited to two hours per day.

e. Performance of an episiotomy or delivery of a placenta by a provider other than the attending physician is covered only through the adjustment process.

6.0 Providers Eligible to Bill for the Procedure

Providers who meet Medicaid's qualifications for participation and are currently enrolled with the N.C. Medicaid program to provide obstetrical services are eligible to bill for these services when the procedure is within the scope of their practice.

7.0 Additional Requirements

7.1 Federal and State Requirements

All providers must comply with all applicable federal and state laws and regulations.

7.2 Records Retention

As a condition of participation, providers are required to keep records necessary to disclose the extent of services rendered to recipients and billed to the N.C. Medicaid program [Social Security Act 1902(a)(27) and 42 CFR 431.107]. Records must be retained for a period of at least five years from the date of service, unless a longer retention period is required by applicable federal or state law, regulations, or agreements (10A NCAC 22F.0107).

Copies of records must be furnished upon request.

The Health Insurance Portability and Accountability Act (HIPAA) does not prohibit the release of records to Medicaid (45 CFR 164.502).

8.0 Policy Implementation/Update Information

Original Effective Date: October 1, 1985

Revision Information:

Date	Section Revised	Change

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity and that most accurately describes the state of pregnancy and outcome of the delivery.

C. Procedure Codes

OB Codes and Guidelines			
CPT Code	**Type**	**Description**	**Guidelines**
59400	Global	Routine obstetric care, including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	• The provider billing for OB care must have rendered at least 3 months of consecutive antepartum care to the recipient. • The date the provider first saw the recipient for antepartum care must be entered in block 15 of the CMS-1500 form. • The date of service on the claim for the OB care must be the date of delivery. • This code cannot be billed in addition to other OB global codes.
59409	Individual	Vaginal delivery only (with or without episiotomy and/or forceps)	• If antepartum care and/or postpartum care are performed by the same provider, the appropriate global code should be billed. • Limited to one unit within 225 days when billed by the same or different provider. • This code cannot be billed in addition to global OB codes.

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OB Codes and Guidelines			
CPT Code	**Type**	**Description**	**Guidelines**
59410	Package	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care	• If antepartum care and/or postpartum care are performed by the same provider, the appropriate global code should be billed. • Limited to one unit within 225 days when billed by the same or different provider. • This code cannot be billed in addition to global OB codes. • Birthing Centers use this code for reimbursement.
59412	Individual	External cephalic version, with or without tocolysis	• Use 59412 in addition to code(s) for delivery.
59414	Individual	Delivery of placenta (separate procedure)	• Cannot be billed in conjunction with another delivery code. • Limited to one unit within 225 days when billed by the same or different provider.
59425	Package	Antepartum care only; 4–6 visits	• The date the provider first saw the recipient for antepartum care must be entered in block 15 of the CMS-1500 form. • The date of service on the claim must be the date of delivery. • This code cannot be billed in addition to other OB global codes. • This code can only be billed once during the pregnancy with one unit by the same provider. (Refer to **Section 5.2,** letter b.) • If delivery and postpartum care are also performed by the same provider, this code should not be billed. A global code that includes all services provided should be selected.

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OB Codes and Guidelines			
CPT Code	**Type**	**Description**	**Guidelines**
59426	Package	Antepartum care only; 7 or more visits	• The date the provider first saw the recipient for antepartum care must be entered in block 15 of the CMS-1500 form. • The date of service on the claim must be the date of delivery. • This code cannot be billed in addition to other OB global codes. • This code can only be billed once during the pregnancy with one unit. • If delivery and postpartum care are also performed by the same provider, this code should not be billed. A global code that includes all services provided should be selected.
59430	Individual	Postpartum care only (separate procedure)	• This code cannot be billed in addition to other OB global codes. • This includes 60 days postpartum. • If delivery and antepartum care are also performed by the same provider, this code should not be billed. A global code that includes all services provided should be selected.
59510	Global	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	• The provider billing for OB care must have rendered at least 3 months of consecutive antepartum care to the recipient. • The date the provider first saw the recipient for antepartum care must be entered in block 15 of the CMS-1500 form. • The date of service on the claim for the OB care must be the date of delivery. • This code cannot be billed in addition to other OB global codes.
59514	Individual	Cesarean delivery only	• If antepartum care and/or postpartum care are performed by the same provider, the appropriate global code should be billed. • Limited to one unit within 225 days when billed by the same or different provider. • This code cannot be billed in addition to global OB codes.

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OB Codes and Guidelines			
CPT Code	**Type**	**Description**	**Guidelines for Physician Services**
59515	Package	Cesarean delivery only; including postpartum care	• Limited to one unit within 225 days when billed by the same or different provider. • If antepartum care is performed by the same provider, the appropriate global code should be billed.
99360	Individual	Physician standby service, requiring prolonged physician attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)	• High-risk deliveries. • Only related to the mother. • Must be requested by a physician and this request must be documented in the medical record. • Diagnosis substantiating the high risk must be listed on the claim form. • Cannot be billed in conjunction with stand-by services for the baby by the same provider. • Cannot be billed on the same date of service as stand-by service for attendance at delivery. • Limited to 2 hours per day. Cannot be billed on the same date of service as CPT codes 99354 through 99357. • Refer to the CPT book for the descriptions and indications for physician standby services.
99436	Individual	Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn	• Cannot be billed in conjunction with newborn resuscitation. • Cannot be billed in conjunction with stand-by services for the baby by the same provider. • Cannot be billed on the same date of service as stand-by service for attendance at delivery by the same provider.

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OB Codes and Guidelines			
CPT Code	**Type**	**Description**	**Guidelines for Anesthesia Services**
99360	Individual	Physician standby service, requiring prolonged physician attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)	• High-risk deliveries. • Only related to the mother. • Must be requested by a physician and this request must be documented in the medical record. • Diagnosis substantiating the high risk must be listed on the claim form. • Cannot be billed in conjunction with stand-by services for the baby by the same provider. • Cannot be billed on the same date of service as stand-by service for attendance at delivery. • Limited to 1 hour (2 units) per day. • Cannot be billed on the same date of service as any other anesthesia codes. • Cannot be billed on the same date of service as CPT codes 99354 through 99357. • Refer to the CPT book for the descriptions and indications for physician standby services.

Postpartum Vaccinations	
CPT Code	**Description**
90396	Varicella-zoster immune globulin, human, for intramuscular use
90706	Rubella virus vaccine, live, for subcutaneous use
90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use
90716	Varicella virus vaccine, live, for subcutaneous use

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OB Codes and Guidelines for FQHC and RHC providers			
CPT Code	**Type**	**Description**	**Guidelines**
T1015 (HCPCS)	Individual	Clinic visit/ encounter, all-inclusive	• Rendering antepartum care is a core service • Use the "A" suffix provider number.
59409	Individual	Vaginal delivery only (with or without episiotomy and/or forceps)	• Postpartum care services are not included in this code. • If postpartum care is performed by the same provider the appropriate global code should be billed. • Limited to one unit within 225 days when billed by the same or different provider. • Use the "C" suffix provider number.
59410	Package	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care	• Limited to one unit within 225 days when billed by the same or different provider. • Use the "C" suffix provider number.
59412	Individual	External cephalic version, with or without tocolysis	• Use 59412 in addition to code(s) for delivery. • Use the "C" suffix provider number.
59414	Individual	Delivery of placenta (separate procedure)	• Cannot be billed in conjunction with another delivery code. • Limited to one unit within 225 days when billed by the same or different provider • Use the "C" suffix provider number.
59430	Individual	Postpartum care only (separate procedure)	• This code cannot be billed in addition to other OB global codes. • This includes 60 days postpartum. • If delivery is also performed by the same provider this code should not be billed. • A global code that includes all services provided should be selected. • Use the "C" suffix provider number.
59514	Individual	Cesarean delivery only	• If postpartum care is performed by the same provider the appropriate global code should be billed. • This code can not be billed in addition to global OB codes. • Limited to one unit within 225 days when billed by the same or different provider. • Use the "C" suffix provider number.

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OB Codes and Guidelines for FQHC and RHC providers			
CPT Code	**Type**	**Description**	**Guidelines**
59515	Package	Cesarean delivery only; including postpartum care	• Limited to one unit within 225 days when billed by the same or different provider. • Use the "C" suffix provider number.
99360	Individual	Physician standby service, requiring prolonged physician attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)	• High-risk deliveries. • Only related to the mother. • Must be requested by a physician and this request must be documented in the medical record. • Diagnosis substantiating the high risk must be listed on the claim form. • Cannot be billed in conjunction with stand-by services for the baby by the same provider. • Cannot be billed on the same date of service as stand-by service for attendance at delivery. • Limited to 2 hours per day. • Cannot be billed on the same date of service as CPT codes 99354 through 99357. • Use the "C" suffix provider number. • Refer to the CPT book for the descriptions and indications for physician standby services.
99436	Individual	Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn	• Cannot be billed in conjunction with newborn resuscitation. • Cannot be billed in conjunction with stand-by services for the baby by the same provider. • Cannot be billed on the same date of service as stand-by service for attendance at delivery by the same provider. • Use the "C" suffix provider number.

D. Billing for Multiple Births

The appropriate multiple gestation diagnosis code must be on the claim for reimbursement.

For multiple deliveries, all vaginally, bill the first birth with appropriate individual or global package code with no modifier, and each consecutive birth with 59409 (vaginal delivery only) and modifier 51 (multiple procedures).

For multiple deliveries, all cesarean, bill the first birth with appropriate individual or global package code with no modifier, and each consecutive birth with 59514 (cesarean delivery only) and modifier 51 (multiple procedures).

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If the first baby is delivered vaginally and one or more via C-section, bill the first birth with appropriate individual or global package code with no modifier, and the C-section birth(s) using modifier 59 (distinct procedural service). If there is more than one C-section delivery, bill with modifier 59 and 51 (multiple procedures).

Note: For multiple births of more than three infants, submit a paper claim with operative notes attached.

E. Modifiers

Providers are required to follow applicable modifier guidelines.

F. Place of Service

Inpatient hospital
Outpatient hospital
Office

G. Co-Payments

Pregnancy-related services are exempt from co-payments.

H. Reimbursement

Providers must bill their usual and customary charges.

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Attachment B: Billing for Obstetrical Services

The CPT procedure codes listed below may not be reimbursed separately if billed with CPT codes 59400, 59410, 59425, 59426, 59430, 59510, or 59515 by the same billing provider.

CPT Code	Laboratory Services
36415	Collection of venous blood by venipuncture
80048	Basic metabolic panel
80050	General health panel
80051	Electrolyte panel
80055	Obstetric panel
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constitutents; non-automated, with microscopy
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constitutents; automated, with microscopy
81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constitutents; non-automated, without microscopy
81003	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constitutents; automated, without microscopy
82731	Fetal fibronectin, cervicovaginal secretions, semiquantitative
83020	Hemoglobin fractionation and quantitation; electrophoresis (eg, A2, S, C, and/or F)
83021	Hemoglobin fractionation and quantitation; chromatography (eg, A2, S, C, and/or F)
83026	Hemoglobin; by copper sulfate method, non-automated
83030	Hemoglobin; F (fetal), chemical
83036	Hemoglobin; glycosylated (A1C)
83045	Hemoglobin; methemoglobin, qualitative
83050	Hemoglobin; methemoglobin, quantitative
83051	Hemoglobin; plasma
83055	Hemoglobin; sulfhemoglobin, qualitative
83060	Hemoglobin; sulfhemoglobin, quantitative
83065	Hemoglobin; thermolabile
83068	Hemoglobin; unstable, screen
83069	Hemoglobin; urine
85046	Blood count; automated differential WBC count, reticulocytes, automated, including one or more cellular parameters (eg, reticulocyte hemoglobin content (CHr), immature reticulocyte fraction (IRF), reticulocyte volume (MRV), RNA content), direct measurement

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CPT Code	Evaluation and Management Services
99201 through 99215	Office visits
99241 through 99245	Office or other outpatient consultations
99251 through 99255	Inpatient consultations